Washington State Department of Social & Health Services
DDD Division of Developmental Disabilities

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

DDD MORTALITY REVIEW

PART 3. REGIONAL QUALITY ASSURANCE REPORT

Upon receipt of Part 1. Provider Report and Part 2. Case Resource Manager Report, the Regional Quality Assurance Program Manager (QAPM) will review the reports, make any recommendations, and complete Part 3. Forward all three parts, along with any other pertinent information, to the DDD Central Office Incident Management Program Manager within **14** calendar days of receipt of the Case Resource Manager Report.

I. GENERAL INFORMATION

1. DECEASED'S LEGAL NAME	2. CLIENT ID NUMBER

3. MANNER OF DEATH

☐ Natural ☐ Suicide ☐ Traffic accident ☐ Pending investigation
☐ Accidental ☐ Homicide ☐ Undetermined

4. Is the region assembling an internal mortality review team to investigate this death further? ☐ Yes ☐ No

5. If yes, list the names of participating individuals and their position titles:

NAME	POSITION/TITLE
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

6. Is an external review being conducted? ☐ Yes ☐ No

7. If yes, list name of lead and affiliation:

NOTE: If a separate regional mortality review team is formed, the recommendations from that team may be sent separately when completed so as not to delay the submission of this report.

II. RECORDS REVIEWED

CHECK ALL RECORDS THAT WERE REVIEWED

☐ Death certificate ☐ Medical records ☐ Motor vehicle accident report ☐ Client files
☐ Death scene investigation ☐ Emergency medical services ☐ Law enforcement
☐ Medical Examiner/Coroner ☐ Fire investigation report ☐ CPS/APS/RCS records
☐ Other: _____
☐ Other: _____
☐ Other: _____

III. SUMMARY

1. WAS PHYSICAL ABUSE OR NEGLECT SUSPECTED AS A FACTOR IN THIS DEATH?

☐ Yes (check all that apply): ☐ No ☐ Unknown
- ☐ Isolated act or omission
- ☐ Pattern of abuse or neglect of person
- ☐ Pattern of abuse or neglect in family
- ☐ Pattern of abuse or neglect by provider

2. IF YES, EXPLAIN

3. Were medical practice issues raised as a result of this review? ☐ Yes ☐ No

4. IF YES, EXPLAIN

5. Were provider policy or practice issues raised as a result of this review? ☐ Yes ☐ No

6. IF YES, EXPLAIN

7. Were DDD policy or practice issues raised as a result of this review? ☐ Yes ☐ No

8. IF YES, EXPLAIN

III. RECOMMENDATIONS

LIST RECOMMENDATIONS AND ANY ADDITIONAL INFORMATION PERTINENT TO THIS INCIDENT BASED UPON YOUR REVIEW.

NAME OF PERSON COMPLETING FORM (PRINT)	POSITION/TITLE	DATE COMPLETED	TELEPHONE NUMBER

REGIONAL ADMINISTRATOR APPROVAL (SIGNATURE)	DATE SIGNED